

Collector: Web Link 1 (Web Link)
Started: Wednesday, June 01, 2016 3:30:16 PM
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PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-504) Provo/Mountainland CoC
Q2: If you serve a Balance of State CoC, which counties is this update for?	Respondent skipped this question
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question
Q4: Contact Information	
Name	Bobi Pace
Organization	Homeless Veterans Fellowship
Email Address	counselor@homelessveterans.org

Q5: Does your community have a written plan to end Veteran homelessness?	Yes
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q7: Who is the CoC point of contact?	
Name:	Stephanie Willmore
Email:	stephaniew@unitedwayuc.org
Organization:	United Way

		Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)		Not Applicable	Not Applicable
Healthcare for Homeless Veterans (HCHV)		Yes	Yes
Grant and Per Diem (GPD) VAMC Liaison		Not Applicable	Not Applicable
Grant and Per Diem (GPD) Providers		Not Applicable	Not Applicable
Community Resource and Referral Center (CRRC)		Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)		Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)		Yes	No
Safe Haven		Not Applicable	Not Applicable
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	Client-level information (e.g. data from the HMIS system; includes identifying information such as the key elements for the by name/master list) Aggregate performance information (e.g. housing placement numbers; length of time homeless, does not include identifying information)		
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)	Client-level information (e.g. data from the HOMES system such as key elements for the by name/master list) Aggregate performance information (e.g. HUD-VASH placement numbers; length of time homeless, GPD information, does not include identifying information		
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	yes Yes		
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Training related to security/privacy and the ability to share data with an outside source that is not the VA (e.g. transmission of PII over VA networks/systems). Assistance getting buy-in from the local VA Medical Center(s) to share data.		
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes		

Q14: Who is lead point of contact for coordinated entry? Name: Organization: Organization Type (VAMC, CoC, SSVF Grantee, etc.) Phone #: Email:	Stephanie Willmore United Way CoC 801-361-8478 stephaniew@unitedwayuc.org
Q15: Is the HUD-VASH program integrated into coordinated entry?	N/A
Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	Respondent skipped this question
Q17: Is the GPD program integrated into coordinated entry?	N/A
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	Respondent skipped this question
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	N/A
Q20: Please list the GPD providers currently serving your community.	Respondent skipped this question
Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	No
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	No

PAGE 4: Part 3: Master List

Q23: Does the community have a master list?	Yes
Q24: If "Yes" to the previous question, is the list one complete document (not multiple parts)?	Yes
Q25: Who manages the master list?	
Name:	Stephanie Willmore/CA team
Role:	CoC lead
Organization:	United Way
Organization Type (VAMC, CoC, SSVF Grantee, etc.):	CoC

Q26: Does your list have the following elements? (Select all that apply.)	Includes all unsheltered Veterans,	
	Includes all Veterans in emergency shelter (regardless of shelter funding source) , Includes all Veterans in transitional housing (GPD, community TH, regardless of funding source)	
Q27: How often do you meet to review and update the master list?	Bi-weekly	
Q28: Currently what are your community's top 3 priorities for ending Veteran homelessness?	VAMC engagement in planning efforts,	
	Designing the system to meet federal benchmark criteria.	
	,	
	Increasing permanent housing options (e.g. landlord engagement, etc.)	

PAGE 5: Part 4: Meetings and Strategy

		(no label)
Case Conferences		Bi-Weekly
Strategic Planning/CoordinationMeetings (Bigger Picture)		No meetings occur
Q30: When are your next three strategic planning/coordination meetings? (Include date, time)	Respondent skipped this question	
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	No	

PAGE 6: Part 5: Federal Criteria/Benchmarks and Support

Q32: Has your community decided to pursue the federal partners' process?	Yes
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	Respondent skipped this question
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	Respondent skipped this question
Q36: List any technical assistance needs. (Select all that apply.)	Assistance with data sharing between VA and community and/or data tracking.

PAGE 7: Part 6: Sustainability

Q37: Has your community begun sustainability planning efforts?	Yes
Q38: What resource gaps (if any) have you identified that may hinder sustainability? Select all that apply	Need for additional permanent supportive housing resources (VA and/or non-VA)
	Need for affordable, permanent housing options
Q39: Does your community currently have Priority 1 (aka "Surge") SSVF funding?	No
Q40: If the answer to the previous question is "yes", does your community have adequate funding resources in place to sustain your system when "surge" funding ends?	Respondent skipped this question
Q41: Does your community regularly follow-up with rapid re-housing clients to ensure housing stabilization?	Yes
Q42: Do you have a system in place to ensure rapid re-	Yes,
housing clients experiencing new housing crises are routed to prevention/other stabilization services?	If yes, please describe this process. We provide information to the clients during case management and at exit to connect them with community resources and phone numbers to call in the event of a crisis. Client's are always connected to other resources in the community.



Collector: Web Link 1 (Web Link)
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PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-503) Utah Balance of State CoC
Q2: If you serve a Balance of State CoC, which counties is this update for?	Weber, Morgan
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question
Q4: Contact Information	
Name	Bobi Pace
Organization	Homeless Veterans Fellowship
Email Address	counselor@homelessveterans.org

Q5: Does your community have a written plan to end Veteran homelessness?	Yes
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q7: Who is the CoC point of contact?	
Name:	Ashley Tolman
Email:	atolman@utah.gov
Organization:	State Community Services Office
Phone #:	801-468-0114

		Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)		Yes	Yes
Healthcare for Homeless Veterans (HCHV)		Yes	Yes
Grant and Per Diem (GPD) VAMC Liaison		Yes	No
Grant and Per Diem (GPD) Providers		Yes	Yes
Community Resource and Referral Center (CRRC)		Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)		Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)		Yes	Yes
Safe Haven		Not Applicable	Not Applicable
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	Client-level information (e.g. data from the HMIS system; includes identifying information such as the key elements for the by name/master list) Aggregate performance information (e.g. housing placement numbers; length of time homeless, does not include identifying information)		ation such as the ter list) n (e.g. housing homeless, does
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)	Client-level information (e.g. data from the HOMES system such as key elements for the by name/master list) , Aggregate performance information (e.g. HUD-VASH placement numbers; length of time homeless, GPD information, does not include identifying information		n (e.g. HUD-VASH homeless, GPD
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	Yes		
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Assistance (Center(s) to	getting buy-in from the share data.	local VA Medical
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes		

Q14: Who is lead point of contact for coordinated entry? Name: Organization: Organization Type (VAMC, CoC, SSVF Grantee, etc.) Phone #: Email:	Summer Rowher Lantern House Emergency Shelter CoC 801-621-5036 srohwer.stannes@gmail.com
Q15: Is the HUD-VASH program integrated into coordinated entry?	Yes
Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	HUD-VASH receives referrals from coordinated entry but also allows for direct entry into their program through other means
Q17: Is the GPD program integrated into coordinated entry?	Yes
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	GPD receives referrals from coordinated entry but also allows for direct entry into their program through other means
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	Yes
Q20: Please list the GPD providers currently serving your	community.
List of Agency Names	Homeless Veterans Fellowship
Total Number of Beds	Up to 13
Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	Yes, If "Yes", please list the agency names. Homeless Veterans Fellowship
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	Respondent skipped this question

PAGE 4: Part 3: Master List

Yes		
No		
Summer Rowher/CA team		
Coordinated assessment leader		
Lantern House Emergency Shelter		
CoC		

Q26: Does your list have the following elements? (Select all that apply.)	Includes all unsheltered Veterans,		
	Includes all Veterans in emergency shelter (regardless of shelter funding source)		
Q27: How often do you meet to review and update the master list?	Bi-Monthly		
Q28: Currently what are your community's top 3 priorities for ending Veteran homelessness?	Master List development.,		
	Designing the system to meet federal benchmark criteria.		
	•		
	Integrating GPD clients into the BNL/Master List.		

PAGE 5: Part 4: Meetings and Strategy

		(no label)
Case Conferences Strategic Planning/CoordinationMeetings (Bigger Picture)		Bi-Weekly Monthly
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	No	

PAGE 6: Part 5: Federal Criteria/Benchmarks and Support

Q32: Has your community decided to pursue the federal partners' process?	Yes
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	Respondent skipped this question
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	Respondent skipped this question
Q36: List any technical assistance needs. (Select all that	Assistance with by name list,
apply.)	Assistance with understanding the federal criteria and benchmarks

Q37: Has your community begun sustainability planning efforts?	Yes
Q38: What resource gaps (if any) have you identified that may hinder sustainability? Select all that apply	Need for additional prevention/rapid re-housing funds (non-SSVF)
	Need for income support / financial management services (e.g. Rep Payee)
	Funding for other intensive case management services for RRH Veterans currently housed but atrisk of returning to homelessness.
Q39: Does your community currently have Priority 1 (aka "Surge") SSVF funding?	No
Q40: If the answer to the previous question is "yes", does your community have adequate funding resources in place to sustain your system when "surge" funding ends?	Respondent skipped this question
Q41: Does your community regularly follow-up with rapid re-housing clients to ensure housing stabilization?	Yes
Q42: Do you have a system in place to ensure rapid re-	Yes,
housing clients experiencing new housing crises are routed to prevention/other stabilization services?	If yes, please describe this process. Client's are always provided with crisis information and referrals to community resources. This information is provided by HVF during enrollment in SSVF and at exit. Client's are always connected to additional community resources and encouraged to call us if needed in the future. Other community providers do this as well.



Collector: Web Link 1 (Web Link) Started: Friday, June 03, 2016 10:32:11 AM Last Modified: Friday, June 03, 2016 10:45:45 AM Time Spent: 00:13:34

PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-503) Utah Balance of State CoC	
Q2: If you serve a Balance of State CoC, which counties is this update for?	Washington	
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question	
Q4: Contact Information		
Name	Bobi Pace	
Organization	Homeless Veterans Fellowship	
Email Address	counselor@homelessveterans.org	

Q5: Does your community have a written plan to end Veteran homelessness?	Yes
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q7: Who is the CoC point of contact?	
Name:	Carol Hollowell
Email:	chollowell@switchpointcrc.org
Organization:	Switchpoint Community Resource Center
Phone #:	435-627-4663

		Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)		Yes	Yes
Healthcare for Homeless Veterans (HCHV)		Yes	No
Grant and Per Diem (GPD) VAMC Liaison		Not Applicable	Not Applicable
Grant and Per Diem (GPD) Providers		Not Applicable	Not Applicable
Community Resource and Referral Center (CRRC)		Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)		Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)		Yes	Yes
Safe Haven		Not Applicable	Not Applicable
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	Client-level information (e.g. data from the HMIS system; includes identifying information such as the key elements for the by name/master list) Aggregate performance information (e.g. housing placement numbers; length of time homeless, does not include identifying information)		ation such as the ter list) n (e.g. housing homeless, does
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)	system such list) , Aggregate p placement r	information (e.g. data for as key elements for the defendance information and between the does not include identification.	ne by name/master n (e.g. HUD-VASH homeless, GPD
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	Yes		
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Respondent question	skipped this	
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes		

Q14: Who is lead point of contact for coordinated entry? Name: Organization: Organization Type (VAMC, CoC, SSVF Grantee, etc.) Phone #: Email:	Toni Tuipulotu Five Counties Association of Governments CoC 435-674-5757 ttuipulotu@fivecounty.utah.gov
Q15: Is the HUD-VASH program integrated into coordinated entry?	Yes
Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	HUD-VASH receives referrals from coordinated entry but also allows for direct entry into their program through other means
Q17: Is the GPD program integrated into coordinated entry?	N/A
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	Respondent skipped this question
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	Yes
Q20: Please list the GPD providers currently serving your List of Agency Names	community. Homeless Veterans Fellowship
Total Number of Beds	Up to 13
Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	Yes, If "Yes", please list the agency names. Homeless Veterans Fellowship
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	Respondent skipped this question
PAGE 4: Part 3: Master List	
Q23: Does the community have a master list?	Yes
Q24: If "Yes" to the previous question, is the list one complete document (not multiple parts)?	Yes
Q25: Who manages the master list? Name: Role: Organization:	Toni Tuipulotu Coordinated Entry POC Five County Association of Governments
Organization Type (VAMC, CoC, SSVF Grantee, etc.):	CoC

Community Plannii	ng - June Submission
Q26: Does your list have the following elements? (Sele	ct Includes all unsheltered Veterans,
all that apply.)	Includes all Veterans in emergency shelter (regardless of shelter funding source)
Q27: How often do you meet to review and update the master list?	Monthly
Q28: Currently what are your community's top 3	Master List development.,
priorities for ending Veteran homelessness?	Establishing a coordinated intake/entry system.,
	Increasing permanent housing options (e.g. landlord engagement, etc.)
PAGE 5: Part 4: Meetings and Strategy	
Q29: What types of meetings does your community have	ve?
	(no label)
Case Conferences	Monthly
Strategic Planning/CoordinationMeetings (Bigger Picture	e) Monthly
Q30: When are your next three strategic planning/coord	dination meetings? (Include date, time)
Meeting 1 06/15/2016 9:30 AM,	
Meeting 2 06/27/2016 9:00 AM,	
Meeting 3 7/20/2016 9:30 AM	
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	No
PAGE 6: Part 5: Federal Criteria/Benchmarks and Support	
Q32: Has your community decided to pursue the federa	al No
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	We do not feel we can meet the criteria/benchmarks
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its currer status (pending, approved, denied).	Respondent skipped this question

status (pending, approved, denied).

Q36: List any technica	l assistance	needs.	(Select all that
apply.)			

Assistance with by name list,

Assistance with data sharing between VA and community and/or data tracking.

,

Assistance with sustainability planning

PAGE 7: Part 6: Sustainability

Q37: Has your community begun sustainability planning efforts?	Yes
Q38: What resource gaps (if any) have you identified that may hinder sustainability? Select all that apply	Need for additional Section 8 (non-VA) housing vouchers
	Need for additional VA funded prevention/rapid rehousing (SSVF)
	Need for additional permanent supportive housing resources (VA and/or non-VA)
	Need for affordable, permanent housing options
Q39: Does your community currently have Priority 1 (aka "Surge") SSVF funding?	No
Q40: If the answer to the previous question is "yes", does your community have adequate funding resources in place to sustain your system when "surge" funding ends?	Respondent skipped this question
Q41: Does your community regularly follow-up with rapid re-housing clients to ensure housing stabilization?	Yes
Q42: Do you have a system in place to ensure rapid re-	Yes,
housing clients experiencing new housing crises are routed to prevention/other stabilization services?	If yes, please describe this process. Clients are always connected to community resources and given community resource lists. SSVF clients are encouraged to contact us if needed in the future.



Collector: Web Link 1 (Web Link) Started: Friday, June 03, 2016 11:19:59 AM Last Modified: Friday, June 03, 2016 3:10:40 PM Time Spent: 03:50:40

PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-503) Utah Balance of State CoC
Q2: If you serve a Balance of State CoC, which counties is this update for?	Tooele, Juab, Millard, Beaver, Iron, Kane, Daggett, Duchesne, Uintah, Carbon, Emery, Grand, Sanpete, Sevier, Piute, Wayne, Garfield, Kane, San Jan
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question
Q4: Contact Information	
Name	Bobi Pace
Organization	Homeless Veterans Fellowship
Email Address	counselor@homelessveterans.org

Phone #:	801-468-0114
Organization:	State Community Services Office
Email:	atolman@utah.gov
Name:	Ashley Tolman
Q7: Who is the CoC point of contact?	
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q5: Does your community have a written plan to end Veteran homelessness?	Yes

		Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)		Yes	No
Healthcare for Homeless Veterans (HCHV)		Yes	No
Grant and Per Diem (GPD) VAMC Liaison		Not Applicable	No
Grant and Per Diem (GPD) Providers		Yes	Yes
Community Resource and Referral Center (CRRC)		Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)		Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)		Yes	No
Safe Haven		Not Applicable	Not Applicable
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	system; incl key elemen , Aggregate p placement r	information (e.g. data ludes identifying information ts for the by name/mass performance information identifying information)	enation such as the ster list) on (e.g. housing the homeless, does
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)		information (e.g. data h as key elements for t	
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	Yes		
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)		getting buy-in from the share data.	local VA Medical
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes		
Q14: Who is lead point of contact for coordinated entry?			
Name:	Bobi Pace		
Organization:	Homeless \	/eterans Fellowship	
Organization Type (VAMC, CoC, SSVF Grantee, etc.)	SSVF		
Phone #:	801-392-76	662	
Email:	counselor@	homelessveterans.org	9

Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	Respondent skipped this question
Q17: Is the GPD program integrated into coordinated entry?	No
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	Respondent skipped this question
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	No
Q20: Please list the GPD providers currently serving your community.	Respondent skipped this question
Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	No
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	Respondent skipped this question

PAGE 4: Part 3: Master List

Q23: Does the community have a master list?	No
Q24: If "Yes" to the previous question, is the list one complete document (not multiple parts)?	Respondent skipped this question
Q25: Who manages the master list?	Respondent skipped this question
Q26: Does your list have the following elements? (Select all that apply.)	Respondent skipped this question
Q27: How often do you meet to review and update the master list?	Respondent skipped this question
Q28: Currently what are your community's top 3 priorities for ending Veteran homelessness?	Master List development.,
	VAMC engagement in planning efforts,
	Establishing a coordinated intake/entry system.

PAGE 5: Part 4: Meetings and Strategy

Q29: What types of meetings does your community have?

	(no label)	
Case Conferences	Monthly	
Strategic Planning/CoordinationMeetings (Bigger Picture)	Monthly	
Q30: When are your next three strategic planning/coordination meetings? (Include date, time)	Respondent skipped this question	
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	No	
AGE 6: Part 5: Federal Criteria/Benchmarks and Support		
Q32: Has your community decided to pursue the federal partners' process?	No	
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	We do not feel we can meet the criteria/benchmark	S.
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No	
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	Respondent skipped this question	
Q36: List any technical assistance needs. (Select all that apply.)	Respondent skipped this question	
AGE 7: Part 6: Sustainability		
Q37: Has your community begun sustainability planning efforts?	Yes	
Q38: What resource gaps (if any) have you identified that may hinder sustainability? Select all that apply	Need for additional Section 8 (non-VA) housing vouchers	
	Need for additional permanent supportive housing resources (VA and/or non-VA)	
Q39: Does your community currently have Priority 1 (aka "Surge") SSVF funding?	No	
Q40: If the answer to the previous question is "yes", does your community have adequate funding resources in place to sustain your system when "surge" funding ends?	Respondent skipped this question	

Q41: Does your community regularly follow-up with
rapid re-housing clients to ensure housing stabilization?

Yes

Q42: Do you have a system in place to ensure rapid rehousing clients experiencing new housing crises are routed to prevention/other stabilization services?

Yes,

If yes, please describe this process. SSVF clients are always given resources in their community and contact numbers in the event of a crisis. They are encouraged to contact us in the future if needed.



Collector: Web Link 1 (Web Link) Started: Friday, June 03, 2016 3:11:54 PM Last Modified: Friday, June 03, 2016 3:23:02 PM Time Spent: 00:11:08

PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-503) Utah Balance of State CoC
Q2: If you serve a Balance of State CoC, which counties is this update for?	Box Elder, Cache, Rich
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question
Q4: Contact Information	
Name	Bobi Pace
Organization	Homeless Veterans Fellowship
Email Address	counselor@homelessveterans.org

Q5: Does your community have a written plan to end Veteran homelessness?	Yes
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q7: Who is the CoC point of contact?	
Name:	Ashley Tolman
Name: Email:	Ashley Tolman atolman@utah.gov
	•

		Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)		No	No
Healthcare for Homeless Veterans (HCHV)		No	No
Grant and Per Diem (GPD) VAMC Liaison		No	No
Grant and Per Diem (GPD) Providers		Yes	Yes
Community Resource and Referral Center (CRRC)		Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)		Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)		Yes	No
Safe Haven		Not Applicable	Not Applicable
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	system; incl key elemen , Aggregate p placement r	information (e.g. data fludes identifying informats for the by name/mass performance information numbers; length of time identifying information)	ation such as the ster list) In (e.g. housing be homeless, does
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)		information (e.g. data the same the sam	
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	Yes		
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Respondent question	t skipped this	
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes		
Q14: Who is lead point of contact for coordinated entry? Name: Organization: Organization Type (VAMC, CoC, SSVF Grantee, etc.) Phone #: Email:	CoC 435-713-14	Association of Governi	ments
Q15: Is the HUD-VASH program integrated into coordinated entry?	No		

Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	Respondent skipped this question
Q17: Is the GPD program integrated into coordinated entry?	No
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	Respondent skipped this question
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	Yes
Q20: Please list the GPD providers currently serving your	community.
List of Agency Names	Homeless Veterans Fellowship
Total Number of Beds	Up to 13
Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	Yes, If "Yes", please list the agency names. Homeless Veterans Fellowship
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	Yes

PAGE 4: Part 3: Master List

Q23: Does the community have a master list?	Yes
Q24: If "Yes" to the previous question, is the list one complete document (not multiple parts)?	Yes
Q25: Who manages the master list?	
Name:	Stephanie Jones
Role:	Homeless Coordinator
Organization:	Bear River Association of Governments
Organization Type (VAMC, CoC, SSVF Grantee, etc.):	CoC
Q26: Does your list have the following elements? (Select	Includes all unsheltered Veterans,
all that apply.)	Includes all Veterans in emergency shelter (regardless of shelter funding source)
Q27: How often do you meet to review and update the master list?	Bi-Monthly

Q28: Currently what are your community's top 3 priorities for ending Veteran homelessness?

Sustainability: Developing written policies and procedures to maintain the master list and case conference processes

VAMC engagement in planning efforts,

Increasing permanent housing options (e.g. landlord engagement, etc.)

PAGE 5: Part 4: Meetings and Strategy

Meeting 2 07/05/2016 3:00 PM,

meetings?

	(no label)
Case Conferences	Monthly
Strategic Planning/CoordinationMeetings (Bigger Picture)	Monthly
Q30: When are your next three strategic planning/coordination meetings? (Include d	ate, time)
Meeting 1 06/07/2016 3:00 PM,	

Meeting 3 08/09/2016 3:00 PM

Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these

Q29: What types of meetings does your community have?

No

PAGE 6: Part 5: Federal Criteria/Benchmarks and Support

Q32: Has your community decided to pursue the federal partners' process?	No
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	We do not feel we can meet the criteria/benchmarks.
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	Respondent skipped this question
Q36: List any technical assistance needs. (Select all that apply.)	Respondent skipped this question

PAGE 7: Part 6: Sustainability

Yes
Need for additional HUD-VASH vouchers, Need for additional Section 8 (non-VA) housing vouchers, Need for additional permanent supportive housing resources (VA and/or non-VA), Need for affordable, permanent housing options
No
Respondent skipped this question
Yes
Yes, If yes, please describe this process. Clients are provided with crisis numbers and community resources; SSVF clients are encouraged to contact their SSVF case manager if the need arises in the future.



Collector: Web Link 1 (Web Link) Started: Friday, June 03, 2016 3:14:59 PM Last Modified: Friday, June 03, 2016 3:35:13 PM Time Spent: 00:20:14

PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-500) Salt Lake City and County CoC
Q2: If you serve a Balance of State CoC, which counties is this update for?	Respondent skipped this question
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question
Q4: Contact Information	
Name	Kevin Austin
Organization	The Road Home
Email Address	kaustin@theroadhome.org

Q5: Does your community have a written plan to end Veteran homelessness?	Yes
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q7: Who is the CoC point of contact?	
Name:	Kerry Steadman
Email:	ksteadman@slco.org
	Salt Lake County Covernment and CoC
Organization:	Salt Lake County Government and CoC

meetings/events.	Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)	Yes	Yes
Healthcare for Homeless Veterans (HCHV)	Yes	No
Grant and Per Diem (GPD) VAMC Liaison	Yes	Yes
Grant and Per Diem (GPD) Providers	Yes	Yes
Community Resource and Referral Center (CRRC)	No	No
Domiciliary Care for Veterans (VA-Dom)	No	No
Veterans Justice Outreach (VJO)	Yes	Yes
Safe Haven	No	No
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	Client-level information (e.g. data from the HMIS system; includes identifying information such as the key elements for the by name/master list) , Aggregate performance information (e.g. housing placement numbers; length of time homeless, does not include identifying information)	
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)	Client-level information (e.g. data is system such as key elements for the list) Aggregate performance information placement numbers; length of time information, does not include identification.	he by name/master on (e.g. HUD-VASH e homeless, GPD
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	Yes	
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Respondent skipped this question	
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes	

Q14: Who is lead point of contact for coordinated entry? Name: Organization: Organization Type (VAMC, CoC, SSVF Grantee, etc.) Phone #: Email:	Kerry Steadman Salt Lake County Government and CoC CoC 385.468.4902 ksteadman@slco.org
Q15: Is the HUD-VASH program integrated into coordinated entry?	Yes
Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	HUD-VASH receives referrals from coordinated entry but also allows for direct entry into their program through other means
Q17: Is the GPD program integrated into coordinated entry?	Yes
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	GPD receives referrals from coordinated entry but also allows for direct entry into their program through other means
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	Yes
Q20: Please list the GPD providers currently serving your	•
List of Agency Names Total Number of Beds	Housing Authority of Salt Lake City 166
Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	Yes, If "Yes", please list the agency names. Housing Authority of Salt Lake City
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	Respondent skipped this question

PAGE 4: Part 3: Master List

Q23: Does the community have a master list?	Yes
Q24: If "Yes" to the previous question, is the list one complete document (not multiple parts)?	Yes
Q25: Who manages the master list?	
Name:	Kevin Austin
Role:	Housing Placement Supervisor
Organization:	The Road Home
Organization Type (VAMC, CoC, SSVF Grantee, etc.):	SSVF Grantee

, ,	
Q26: Does your list have the following elements? (Select all that apply.)	Includes all unsheltered Veterans,
	Includes all Veterans in emergency shelter (regardless of shelter funding source)
	Includes all Veterans in transitional housing (GPD, community TH, regardless of funding source)
Q27: How often do you meet to review and update the master list?	Weekly
Q28: Currently what are your community's top 3	Master List development., Data sharing,
priorities for ending Veteran homelessness?	Establishing a coordinated intake/entry system.
PAGE 5: Part 4: Meetings and Strategy	
Q29: What types of meetings does your community have?	,
	(no label)
Case Conferences	Weekly
Strategic Planning/CoordinationMeetings (Bigger Picture)	Bi-Weekly
Q30: When are your next three strategic planning/coordin	ation meetings? (Include date, time)
Meeting 1 06/14/2016 11:00 AM,	
Meeting 2 06/28/2016 11:00 AM,	
Meeting 3 07/12/2016 11:00 AM	
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	No
PAGE 6: Part 5: Federal Criteria/Benchmarks and Support	
Q32: Has your community decided to pursue the federal partners' process?	Yes
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	Respondent skipped this question
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	Respondent skipped this question
Q36: List any technical assistance needs. (Select all that apply.)	Assistance with data sharing between VA and community and/or data tracking.

PAGE 7: Part 6: Sustainability

Q37: Has your community begun sustainability planning efforts?	Yes
Q38: What resource gaps (if any) have you identified that	Need for additional HUD-VASH vouchers,
may hinder sustainability? Select all that apply	Need for additional Section 8 (non-VA) housing vouchers
	,
	Need for affordable, permanent housing options,
	Funding for other intensive case management services for RRH Veterans currently housed but atrisk of returning to homelessness.
Q39: Does your community currently have Priority 1 (aka "Surge") SSVF funding?	No
Q40: If the answer to the previous question is "yes", does your community have adequate funding resources in place to sustain your system when "surge" funding ends?	Respondent skipped this question
Q41: Does your community regularly follow-up with rapid re-housing clients to ensure housing stabilization?	No
Q42: Do you have a system in place to ensure rapid re- housing clients experiencing new housing crises are routed to prevention/other stabilization services?	No



Collector: Web Link 1 (Web Link) Started: Friday, June 03, 2016 3:32:15 PM Last Modified: Friday, June 03, 2016 3:40:20 PM Time Spent: 00:08:05

PAGE 2: Part 1: Demographics

Q1: Choose your Continuum of Care Code:	(UT-503) Utah Balance of State CoC
Q2: If you serve a Balance of State CoC, which counties is this update for?	Davis
Q3: If you are submitting a plan for CA-600, what is the SPA number associated with your update?	Respondent skipped this question
Q4: Contact Information	
Name	Bobi Pace
Organization	Homeless Veterans Fellowship
Email Address	counselor@homelessveterans.org

Q5: Does your community have a written plan to end Veteran homelessness?	Yes
Q6: If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?	Yes
Q7: Who is the CoC point of contact?	
Name:	Kim Michaud
Email:	kim@daviscommunityhousing.com
Organization:	Davis County Housing Authority
Organization.	

		Strategic Meetings	Case Conferencing/Mast er List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)		Yes	Yes
Healthcare for Homeless Veterans (HCHV)		Yes	No
Grant and Per Diem (GPD) VAMC Liaison		No	No
Grant and Per Diem (GPD) Providers		Yes	Yes
Community Resource and Referral Center (CRRC)		Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)		Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)		Yes	Yes
Safe Haven		Not Applicable	Not Applicable
Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	system; incl key element , Aggregate p placement r	information (e.g. data fudes identifying informats for the by name/mass performance information identifying information)	ation such as the ster list) n (e.g. housing homeless, does
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)	system such list) , Aggregate p placement r	information (e.g. data for as key elements for the deformance information does not include identification.	n (e.g. HUD-VASH homeless, GPD
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	Yes		
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Respondent question	skipped this	
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	Yes		

Q14: Who is lead point of contact for coordinated entry? Name: Heidi Patterson Organization: Safe Harbor Hope Organization Type (VAMC, CoC, SSVF Grantee, etc.) CoC Phone #: 801-444-3191 Email: heidi@safeharborhope.org Q15: Is the HUD-VASH program integrated into Yes coordinated entry? HUD-VASH receives referrals from coordinated entry Q16: If the answer was "Yes" to the previous question, but also allows for direct entry into their program please select the response that best describes this through other means integration: No Q17: Is the GPD program integrated into coordinated entry? Respondent skipped this Q18: If the answer to the previous question was "Yes", question please select the response that best describes this integration: Yes Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".) Q20: Please list the GPD providers currently serving your community. List of Agency Names Homeless Veterans Fellowship **Total Number of Beds** Up to 13 Yes Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office? Respondent skipped this Q22: If "No" to question 21, are any GPD providers question planning to submit a change of scope? PAGE 4: Part 3: Master List Yes Q23: Does the community have a master list? Yes Q24: If "Yes" to the previous question, is the list one

complete document (not multiple parts)?		
Q25: Who manages the master list?		
Name:	Heidi Patterson	
Role:	Coordinated Entry POC	
Organization:	Safe Harbor Hope	
Organization Type (VAMC, CoC, SSVF Grantee, etc.):	CoC	

Community Framming	
Q26: Does your list have the following elements? (Select all that apply.)	Includes all unsheltered Veterans,
	Includes all Veterans in emergency shelter (regardless of shelter funding source)
Q27: How often do you meet to review and update the master list?	Monthly
Q28: Currently what are your community's top 3 priorities for ending Veteran homelessness?	VAMC engagement in planning efforts,
	Designing the system to meet federal benchmark criteria.
	1
	Increasing permanent housing options (e.g. landlord engagement, etc.)
AGE 5: Part 4: Meetings and Strategy	
Q29: What types of meetings does your community have?	
	(no label)
Case Conferences	Monthly
Strategic Planning/CoordinationMeetings (Bigger Picture)	Monthly
Q30: When are your next three strategic planning/coording	ation meetings? (Include date, time)
Meeting 1 06/14/2016 1:00 PM,	
Meeting 2 07/12/2016 1:00 PM,	
Meeting 3 08/09/2016 1:00 PM	
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	No
AGE 6: Part 5: Federal Criteria/Benchmarks and Support	
Q32: Has your community decided to pursue the federal partners' process?	Yes
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	Respondent skipped this question
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	Respondent skipped this question

Q36: List any technical assistance needs. (Select all that apply.)

Respondent skipped this question

PAGE 7: Part 6: Sustainability

Yes	
Need for affordable, permanent housing options	
No	
Respondent skipped this question	
Yes	
Yes, If yes, please describe this process. Clients are encouraged to follow up with SSVF case managers in the event of a crisis and are also linked to community resources during engagement in the program and at exit.	